

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Downtown Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 424 S Adams St Fort Worth, TX 76104	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the resident's right to be free from abuse for one (Resident #1) of 4 residents reviewed for abuse, in that: On 09/16/2025 the facility failed to ensure that Resident #1 was not spoken to in a verbally abusive way by CNA A who called Resident #1 an expletive. This failure could result in resident abuse and mental decline. Findings included:Record review of Resident #1's admission record revealed a [AGE] year-old female admitted on [DATE] with a primary diagnosis of [NAME]-[NAME] Syndrome (a rare genetic disorder characterized by a constant feeling of hunger (hyperphagia), which leads to obesity if not managed.)Review of Resident #1's Quarterly Minimum Data Set, dated [DATE] revealed a BIMS score of 09(Moderate cognitive impairment.) Review of Resident #1's Care Plan dated 11/24/2025 revealed Focus: Behavior: Resident #1 exhibits maladaptive behavior at times r/t intellectual disability poor coping skills behave at an age lower than her chronological age impaired cognition. Intervention: Caregivers to provide opportunity for positive interaction, attention. Stop and talk with her as passing by. Focus; Cognitive Status; Resident #1 has impaired cognitive function R/T [NAME]-[NAME] Syndrome. Interventions: Attempt to NOT react to negative behavior. In an interview with Resident #1 on 11/25/2025 at 10:39 AM revealed; she stated I remember when she (CNA A) called me a bitch. She stated she felt bad when staff called her a name. Interview with HR conducted on 11/25/2025 at 10:45 AM revealed she stated she was in her office and heard words going back and forth between Resident #1 and staff. She stated she was able to denote Resident #1's voice and heard the word bitch and then heard another voice (identified as CNA A) respond you a bitch, too. She stated she left her office and went to look for CNA A. When she arrived at Resident #1's room the resident stated that lady just called me a bitch. She stated she located CNA A in another resident's room and asked what happen with Resident #1. She stated CNA A did not deny that she cussed at Resident #1. She stated she told CNA A that language was unprofessional, followed by reporting the suspected abuse to Administration. In an interview with SW on 11/25/2025 at 11:06 AM revealed she conducted the trauma assessment for Resident #1; however, due to Resident #1's impaired cognitive level she was unable to answer questions. Attempted interview with CNA A on 11/25/2025 at 3:05 PM revealed call went to voicemail; message left with reason for calling and call back number. In an interview with DON on 11/25/2025 at 3:44 pm revealed she learned of the incident the CNA A was suspended immediately, staff were educated not to engage with Resident #1 when she used inappropriate language. The staff are in-serviced on respect and dignity of resident's rights. The risk was it created an unsafe environment where the resident would feel unsafe.In an interview with ADMIN on 11/25/2025 at 4:24 PM revealed CNA A was suspended immediately and investigation was conducted. Resident #1 identified CNA A as the one who cussed at her. She stated CNA A admitted to calling Resident #1 the word in response to being called bitch. The expectation was staff should have maintained a professional behavior even when Resident use foul language. The risk was it made the resident feel less than, demined and hurt feelings. Record review of Exclusions Search Results for CNA A dated 06/09/2025 revealed; no results were found.Record review of Texas Unified Licensure Tinfomration Portal undated revealed; CNA A had a NA Certification Status of Active and current Certified Nurse Aide certificate.Record review of employee training transcript dated 06/23/2025 revealed; CNA A received Abuse and Neglect Prevention and Reporting training. Record review Downtown Health and Rehabilitation Center Termination form dated 09/17/2025 revealed; CNA A was terminated on 09/17/2025. Reason for separation; Veral abuse towards resident. Last day worked 09/16/2025 not eligible for rehire based on verbal abuse. Record review of in-training attendance roster dated 09/17/2025 revealed; personnel from all departments were in-service on topics; Abuse/Neglect and Behavior Management. The in-service materials reviewed were Abuse/neglect policy, Behavior Management Policy and De-escalation Training. Record review of Abuse policy revised 3/29/2018 revealed Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability.</p>		